MDR Tracking Number: M5-04-3324-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 05-21-04. CPT code 97122 on date of service 08-11-03 was withdrawn on 08-11-04 by ___, Billing Coordinator at the requestor's office.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, therapeutic exercise, manual therapy, therapeutic activities, neuromuscular re-education, electric stimulation and massage therapy from 08-06-03 through 09-16-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 08-06-03 through 09-16-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 12th day of August 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3324-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 9, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing repetitive stress injury to her right upper extremity on ___. She presented initially to Dr. D, for medical evaluation on 05/01/03. The patient was diagnosed with shoulder strain and tendonitis and was prescribed medications and physical therapy. The patient attended St. David's Occupational therapy services and was returned to work without restrictions. As of 05/15/03, the patient notes an 80-90% overall improvement. Occupational medicine follow-up with a Dr. W on 07/15/03 suggests that the patient has experienced an exacerbation. The patient is given additional medications and returned to work with instructions for frequent breaks. On 07/31/03 the patient appears to change treating doctors to a Dr. L, and is diagnosed with chronic overuse syndrome with tendonitis. Dr. L prescribes additional physical therapy with ___, PT, for 3x per week for 4 weeks. The patient appears to progress well with this therapeutic program and is found at MMI on 09/18/03 with 0% WP impairment.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99204), therapeutic exercise (97110), manual therapy (97140), therapeutic activities (97530), neuromuscular reeducation (97112), electric stimulation 97014) and massage therapy (97124) for period in dispute 08/06/03 through 09/16/03.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Medical necessity for these ongoing treatments and services (08/06/03 through 09/16/03) do appear reasonably **supported** by available documentation. With established exacerbation and well documented

progressive improvement with resolution, these services appear to be reasonable and appropriate.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.
3. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.